

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001016		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/17/2026	
NAME OF PROVIDER OR SUPPLIER Charleston Rehab and Nursing				STREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET , CHARLESTON, Illinois, 61920			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigations: 25612464/2695953 25611990/2688242		S0000			03/09/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow		S9999			03/09/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on record review, and interview, the facility failed to identify appropriate targeted intervention post previous fall, for a resident (R1) with severe cognitive impairment, failed to maintain a mobility device within R1's reach to prevent an unwitnessed fall, failed to initiate neurological and physical assessments post the unwitnessed fall. These failures affected one of three residents (R1) reviewed for falls on the sample list of 18. These failures resulted in a severe head injury and untreated pain. Findings include: R1's most recent Diagnoses List included the following: Carcinoma of the left Bronchus in Situ; Senile Degeneration of the Brain; Chronic Respiratory failure with Hypoxia; Hypertensive Heart Disease with Heart Failure; Chronic Kidney Disease stage IV; disorder of muscle, unspecified; unsteadiness on feet; and other lack of coordination. R1's Minimum Data Set (MDS), dated 10/4/25 (prior to R1's three unwitnessed falls on 10/7/25, 10/28/25, and		S9999				

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S9999	Continued from page 2 12/06/25 described below), documents R1's Brief Interview of Mental Status score as five out of 15, indicating severe cognitive impairment. The same MDS documents R1 had no falls during the assessment look-back period, required supervision and contact assistance with toileting, and required a wheelchair for mobility. R1's Fall Investigation Report dated 10/7/25 at 10:30 p.m. documents R1 had an unwitnessed fall while getting up to go to the bathroom and fell over the recliner chair footrest. The same report documents that R1 hit her face on the floor and that V5, R1's Power of Attorney (POA), wanted R1 sent to the hospital. R1's corresponding Health Status Note dated 10/08/25 at 12:58 a.m. documents R1 returned with a small laceration to her head, no dressing, and no new orders. The facility's Fall Log/Analysis documents R1's fall intervention for 10/08/25 as: "Make sure R1's call light was within reach and functioning." (R1 has severe cognitive impairment; V2, Director of Nursing, confirmed below this was not an appropriate intervention.) This intervention had already been in place since 03/10/25. There was no new targeted intervention to address toileting or the footrest documented after the fall of 10/7/25. R1's Fall Investigation Report dated 10/28/25 at 2:05 a.m. documents R1 had an unwitnessed fall and could not say what happened. The same report documents R1 was found on the floor. The intervention documented was to educate R1 to activate her call light when she needed help and wait for assistance (R1 has severe cognitive impairment, and V2 confirmed this was not an appropriate intervention). R1's Fall Incident Report dated 12/06/25 at 7:30 p.m. documents V11, Licensed Practical Nurse (LPN), as the person preparing the report. The same report documents: Nurse's Description: "Resident was moving from one bed to the other in her room and fell on the floor. Resident has a small bump to her head by the right eye on forehead. Resident states she has no pain; head does not hurt. Vitals were taken." Resident Description: "Resident stated she was trying to get to the other bed when she slipped and fell." Immediate Action Taken: Vital signs taken (completed by			S9999			

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S9999	Continued from page 3 V31, Certified Nursing Assistant (CNA), according to interview below), resident assessed and helped back to bed, and instructed to use call light for help (R1 has severe cognitive impairment as noted above). V31's interview, documented below, stated V31 was the staff member who found R1 on the floor and that R1's wheelchair was across the room, out of R1's reach, when she was found. R1's Care Plan documents a fall intervention dated 3/10/25 stating assistive devices will be within reach of the resident. R1's Neurological Assessment Flow Sheet initiated 12/06/25 documents the following required checks: Every 15 minutes for one hour Every hour for four hours Every four hours for 19 hours The same Neurological Assessment Flow Sheet documents the following for 12/06/25 at 7:30 p.m.: Level of Consciousness: S (stuporous, near unconsciousness) Pupil response: blank (not measured) Hand grips: blank (not measured) Motor function extremities: U (unable to follow directions) Pain: blank (not measured) Vital signs (blood pressure, temperature, pulse, respiration): blank (not measured) Observations: blank Signature: blank (nurse not identified) The same form documents that all assessment boxes were blank at the following times: 7:45 p.m. 8:00 p.m. 8:15 p.m. 9:15 p.m. 10:15 p.m. 11:15 p.m. 3:15 a.m. on 12/07/25 R1's Medication Administration Record (MAR) dated December 2025 documents the following medications were not administered to R1 on 12/06/25: Lorazepam Oral Concentrate 2 mg/mL, give 0.25 mL by mouth every four hours as needed for anxiety, agitation, or restlessness (hospice admission order), and Morphine Sulfate Concentrate Oral Solution 20 mg/mL, give 0.25 mL by mouth every two hours as needed for pain and dyspnea (hospice admission order). On 2/6/26 at 1:30 p.m., R1's family members/complainants V7 and V8 stated they had not been notified of R1's fall. V7 stated, "We would have come in right away. It happened early evening (12/06/25)." V7 and V8 also stated they had been told by an unidentified CNA that "The nurse (V11, LPN) told two CNAs (V31 and V32) to get R1 up off the floor and put her back in bed without the nurse completing an assessment. The nurse told the CNAs she would give R1 morphine. I hope she did. When I saw her, she was moaning, and her face was swollen and bruised. She had to be in a great deal of pain." On 2/6/26 at 3:20 p.m., V10, LPN, stated that when she came to work on 12/07/25, V11 told her in report that			S9999			

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S9999	Continued from page 4 R1 had fallen the evening of 12/06/25 at 7:30 p.m. V10 also stated there was no documentation that V11 had completed neurological assessments or contacted a physician, hospice, or family about R1's fall. V10 stated she tried to reach family and hospice, and both came into the facility right away. V10 also stated R1 was lethargic, could not talk, but moaned during her assessment. On 2/09/26 at 10:30 a.m., V5, Hospice Registered Nurse (RN), confirmed hospice was not notified of the 12/06/25 7:30 p.m. fall until 12/07/25 at approximately 8:00 a.m. V5 stated, "It's protocol for hospice to be notified immediately of falls. We come out and do our own assessment. R1 was in decline prior, but she was still alert and could have conversations the day before. She was totally different when I came in on 12/7/25 to see her. She had obviously taken a serious fall and needed to be evaluated sooner. She could not hold a conversation. She was lethargic." V5 also stated, "From my experience as a hospice nurse, R1 had a concussion and likely a brain bleed. She was comatose post-fall, had a change in swallowing and breathing, and showed no emotion. Had the facility called the night of 12/06/25, hospice staff would have been bedside to provide comfort and emotional support, as we did once we were notified." On 2/11/26 at 3:25 p.m., V2, Director of Nursing (not employed at the facility when R1 fell but experienced in investigating falls), reviewed investigations for R1's falls on 10/7/25, 10/28/25, and 12/06/25, along with care plans, assessments, neurological assessments, vital-sign documentation, interventions, and fall reports. V2 stated it is standard practice to thoroughly assess a resident post-fall. V2 confirmed the following: neurological assessments were not completed after the 12/06/25 fall; no appropriate notifications were made to family, physician, or hospice; no thorough investigation was conducted to determine root cause; reminding R1 to use the call light was not appropriate due to R1's cognitive impairment; and toileting should have been addressed after the 10/07/25 fall since R1 had been attempting to go to the bathroom independently. On 2/13/26 at 11:35 a.m., V31, CNA, stated she was R1's CNA the night R1 fell. V31 stated she heard R1 say, "Help me," looked into R1's room, and saw her lying on the floor between her bed and the bathroom. V31 stated R1 could not speak words and was mumbling and groaning. V31 reported R1 appeared to be in pain and notified V11 immediately. V31 stated that when V11 came in, she did not assess R1 and told staff to get her up. V31 stated		S9999				

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S9999	Continued from page 5 R1 had a large bump above her right eyebrow that swelled immediately and that R1 did not have her oxygen on. V31 stated they attempted to stand R1, but her legs gave out, and they dragged her to the bed. V31 stated V11 left the room immediately afterward. V32 then obtained vital signs. V31 stated R1 continued moaning and appeared in pain. V31 reported V11 later said she would give morphine but instead sat at the desk on her phone and reading. On 2/13/26 at 2:25 p.m., V11, LPN, stated it was a "really hectic night" when R1 fell and acknowledged she did not complete a full physical or neurological assessment. V11 confirmed R1 was moaning in pain at times throughout the night. Although R1's MAR does not document administration of morphine after the fall, V11 stated she was not sure whether she had given it. The facility's Policy and Procedure Fall Reduction Policy, revised 10/30/25, documents: 4.a.ii. Evaluate/assess the resident for injury. Guidelines will be utilized as appropriate to each situation and change in condition. Notify the physician. Notify the responsible party. Contact on-call nurse. The facility's Policy and Procedure Neurological Assessment, dated 11/05/25, states the purpose is to evaluate condition and provide professional nursing assessment and intervention for possible head injuries. General assessment guidelines include, but are not limited to: new onset changes in cognitive status; speech or communication changes; sensory changes; swallowing changes; balance and gait changes; headaches, dizziness, pupillary constriction, weakness, tremors, nausea, or vomiting; drowsiness or irritability; fluid or bleeding from ears; and changes in respiratory pattern. (A)		S9999				